Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MEMORIAL HERMANN HOSPITAL SYSTEM
3200 SW FREEWAY SUITE 2200
HOUSTON TX 77027

Respondent Name

HARTFORD UNDERWRITERS INSURANCE

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-07-3384-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated January 22, 2007 : "Memorial Hermann Hospital System ('Memorial Hermann') submitted its UB92 and itemized statement reflecting ICD-9 code 805.4. Pursuant to Rule 134.401(c)(5) (trauma admit based upon ICD codes), reimbursement is based upon the hospital's fair and reasonable and usual and customary charges, which is $228,312.50. Hartford Claim Exchange Center issued an underpayment of $128,060.17 as a fair and reasonable reimbursement for trauma admit. However, under the rule, this claim qualifies for trauma reimbursement and additional reimbursement of $100,252.33 is due and owing to the hospital."

Requestor's Supplemental Position Summary dated December 12, 2011: "Enclosed please find the Curriculum Vitae and Affidavit of Patricia L. Metzger, Chief of Care Management for Memorial Hermann. Ms. Metzger has extensive knowledge of medical care, treatment plans, and inherently complicated surgical procedures which would require extensive services and supplies by hospital providers. With respect to this case, Ms. Metzger unequivocally states that the medical services and supplies provided to the patient were complicated and extensive."

Amount in Dispute: $100,252.33

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated April 16, 2008: "Our review finds that the carrier processed billing according to Rule 134.401(c)(5). The provider has been reimbursed at a fair and reasonable rate and no additional monies would be due."

Respondent's Supplemental Position Summary dated January 19, 2012: "Hartford reimbursed Provider $128,060.17. Every revenue code was reimbursed at between approximately 75 and 100% of billed charges with the exception of revenue code 360 (OR services) which was reimbursed at approximately 67% of billed charges and revenue code 278 (implants) which was reimbursed at the cost of the implants plus ten 10%." "Provider seeks reimbursement for the difference between its billed charges and the amount paid. For the reasons stated below, it is not entitled to additional reimbursement." "The letter and accompanying affidavit filed by Provider on December 14, 2011 are not relevant to the issues in this case." "The affidavit claims that the services provided were unusually extensive. Provider has filed this same affidavit in numerous 'stop-loss' cases. However, this is not a stop-loss case. Therefore, the issue is not whether the services provided were unusually extensive and costly…As explained below, the issue in a 'trauma' case is whether the amount sought by the provider is a 'fair

and reasonable' rate of reimbursement consistent with the applicable standards." "First, it should be noted that 'usual and customary' is not a reimbursement standard – it is a billing standard." "Second, the former Acute Care Inpatient Hospital Fee Guideline plainly states at (c)(5), 'When the following ICD-9 codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate: (A) Trauma (ICD-9 codes 800.0-959.50).'" "As the party seeking relief, Provider has the burden of proof to show that the amount of reimbursement it seeks is fair and reasonable reimbursement within the meaning of section 413.011 of the Act."

Response Submitted by: Stone Loughlin & Swanson, LLP, on behalf of Hartford Underwriters Insurance, 3508 Far West Blvd., Suite 200, Austin, TX 78731

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 31, 2006 Through February 14, 2006	Inpatient Services	$100,252.33	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on January 23, 2007.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of Benefits dated April 6, 2006

   - W1-Workers comp state fee sched adjust. submitted services were repriced in accordance with state per diem guidelines.
   - W1-WC state fee sched adjust. submitted services are considered inclusive under the state per diem guidelines.
   - W1F-When medically necessary, implantables & orthotics and prosthetics are reimbursed at cost to the hospital plus 10% per the Texas Acute Care Inpatient Hospital Fee Guideline, page 70.
   - W1-Wrkrs comp state fee schedule adjustment. Reduced to fair and reasonable in addition to the normal per diem reimbursement according to rule 134.401(c)(4)(B).

   Explanation of Benefits dated August 2, 2006

   - W4-No addl reimbursement allowed after review of appeal/reconsideration reimbursement for your no additional monies are being paid at this time bill has been paid according to state fee guidelines or rules and regulations.
   - W3-Additional payment made on appeal/reconsideration reimbursement for your resubmitted invoice is based upon documentation and/or additional information provided.

Explanation of Benefits dated August 3, 2006

- W1-Workers comp state fee sched adjust. submitted services were repriced in accordance with state per diem guidelines.
- W4-No addl reimbursement allowed after review of appeal/reconsideration reimbursement for your no additional monies are being paid at this time bill has been paid according to state fee guidelines or rules and regulations.
- W1-WC state fee sched adjust. submitted services are considered inclusive under the state per diem guidelines.
- W3-Additional payment made on appeal/reconsideration. Reimbursement for your resubmitted invoice is based upon documentation and/or additional information provided.
- W1-Workers compensation state fee schedule adjustment, when medically necessary, implantables & orthotics and prosthetics are reimbursed at cost to the hospital plus 10% per the Texas Acute Care Inpatient Hospital Fee Guideline.
- W1-Wrkrs comp state fee schedule adjustment. Reduced to fair and reasonable in addition to the normal per diem reimbursement according to rule 134.401(c)(4)(B).
- W4-No addl reimbursement allowed after review of appeal/reconsideration. Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time, this bill was previously paid.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 805.4. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor asks to be reimbursed the full amount of the billed charges in support of which the requestor states "Pursuant to Rule 134.401(c)(5) (trauma admit based upon ICD codes), reimbursement is based upon the hospital's fair and reasonable and usual and customary charges, which is $228,312.50."
   - The requestor's supplemental position statement asserts that "With respect to this case, Ms. Metzger unequivocally states that the medical services and supplies provided to the patient were complicated and extensive."
   - In support of the requested reimbursement, the requestor submitted an affidavit from Ms. Metzger. However; review of the affidavit finds that the submitted information does not support the requested reimbursement amount or the reimbursement methodology proposed by the requestor.
   - The requestor did not discuss or explain how it determined that reimbursement of the entire amount billed would yield a fair and reasonable reimbursement.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.

- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date
Signature	Health Care Business Management Director	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.